

		FOR OHF USE					

LL 1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0007781</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Columbus Manor Residential Care Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>5107 West Jackson Boulevard</u> <u>Chicago</u> <u>60644</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>773-378-5490</u> Fax # <u>773-378-7860</u>		Officer or Administrator of Provider	
IDPA ID Number: <u>36-2673116001</u>		(Type or Print Name) <u>Patrick J. O'Brien</u>	
Date of Initial License for Current Owners: <u>June 17, 1999</u>		(Title) <u>Administrator</u>	
Type of Ownership:		(Signed) _____ (Date) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		Paid Preparer (Print Name and Title) <u>See Attached Compilation Report</u> (Firm Name & Address) <u>Zoller, Swanson & Co. CPAs</u> <u>125 N. Marion, Oak Park, IL 60301</u> (Telephone) <u>708-763-9647</u> Fax # <u>708-763-8852</u>	
In the event there are further questions about this report, please contact: Name: <u>Patrick J. O'Brien</u> Telephone Number: <u>773-378-5490</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

STATE OF ILLINOIS

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Facility Name & ID Number Columbus Manor Residential Care Home# 0007781 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>189</u>	Intermediate (ICF)	<u>189</u>	<u>68,985</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>189</u>	TOTALS	<u>189</u>	<u>68,985</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>65,335</u>			<u>65,335</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>65,335</u>			<u>65,335</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.71%

D. How many bed-hold days during this year were paid by Public Aid?

973 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☒ NO ☐H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐I. On what date did you start providing long term care at this location?
Date started 0/0/66

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 05/01/79 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary None

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	121,852	25,248	7,391	154,491		154,491		154,491		1
2	Food Purchase		283,514		283,514	(21,972)	261,542		261,542		2
3	Housekeeping	74,163	11,581	4,462	90,206		90,206		90,206		3
4	Laundry	21,710	16,115	1,407	39,232		39,232		39,232		4
5	Heat and Other Utilities			93,139	93,139		93,139		93,139		5
6	Maintenance	81,796	8,857	133,826	224,479		224,479		224,479		6
7	Other (specify):*										7
8	TOTAL General Services	299,521	345,315	240,225	885,061	(21,972)	863,089		863,089		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	698,349	10,582	21,959	730,890		730,890		730,890		10
10a	Therapy										10a
11	Activities	116,390	571	69,852	186,813		186,813		186,813		11
12	Social Services	70,173		21,674	91,847		91,847		91,847		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	884,912	11,153	113,485	1,009,550		1,009,550		1,009,550		16
	C. General Administration										
17	Administrative	88,576			88,576		88,576		88,576		17
18	Directors Fees										18
19	Professional Services			42,304	42,304		42,304		42,304		19
20	Dues, Fees, Subscriptions & Promotions			9,709	9,709		9,709		9,709		20
21	Clerical & General Office Expenses	76,943		46,547	123,490		123,490	(2,303)	121,187		21
22	Employee Benefits & Payroll Taxes			118,858	118,858	21,972	140,830		140,830		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,262	8,262		8,262	(600)	7,662		25
26	Insurance-Prop.Liab.Malpractice			83,203	83,203		83,203	(23,838)	59,365		26
27	Other (specify):* Contributions			6,390	6,390		6,390	(6,390)			27
28	TOTAL General Administration	165,519		315,273	480,792	21,972	502,764	(33,131)	469,633		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,349,952	356,468	668,983	2,375,403		2,375,403	(33,131)	2,342,272		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			31,021	31,021		31,021		31,021			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			78,586	78,586		78,586		78,586			33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* IL SALES TAX			20,816	20,816		20,816		20,816			36
37	TOTAL Ownership			250,423	250,423		250,423	(120,000)	130,423			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,597	1,105	8,702		8,702		8,702			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,316	108,316		108,316		108,316			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		7,597	109,421	117,018		117,018		117,018			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,349,952	364,065	1,028,827	2,742,844		2,742,844	(153,131)	2,589,713			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/00

Ending:

12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care			1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals			4
5	Telephone, TV & Radio in Resident Rooms			5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation			9
10	Interest and Other Investment Income			10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(2,303)	C21-3	13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)	(600)	C25-3	16
17	Non-Care Related Fees			17
18	Fines and Penalties			18
19	Entertainment			19
20	Contributions	(6,390)	C27-3	20
21	Owner or Key-Man Insurance	(23,838)	C26-3	21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt			24
25	Fund Raising, Advertising and Promotional			25
26	Income Taxes and Illinois Personal Property Replacement Tax			26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,131)		\$ 30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*		31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	(226,667)	SCH VII 34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (226,667)	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (259,798)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38	Medically Necessary Transport.		\$		38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)		\$		47

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
13		13
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71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

Summary A

12/31/00

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

STATE OF ILLINOIS

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Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	Rent	\$ 120,000	CMLLC	0.00%	\$ (120,000)	\$ (240,000)	1
2	V	Depreciation		CMLLC	0.00%	13,333	13,333	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 120,000			\$ (106,667)	\$ * (226,667)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Patrick J. O'Brien	Administrator	CEO/Administrato	0.00	None	40	1.00	Salary & Bonu	\$ 88,576	17-4	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 88,576		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Columbus Manor Residential Care Home# 0007781

Report Period Beginning:

1/1/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Columbus Manor Residential Care Home**# **0007781**

Report Period Beginning:

1/1/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	78,537	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	76,645	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(1,892)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	80,478	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	78,586	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	64,463	8		FOR OFF USE ONLY	
	1996	66,049	9			
	1997	75,817	10	13	FROM R. E. TAX STATEMENT FOR 1999	\$
	1998	83,999	11	14	PLUS APPEAL COST FROM LINE 5	\$
	1999	76,645	12	15	LESS REFUND FROM LINE 6	\$
				16	AMOUNT TO USE FOR RATE CALCULATION	\$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

41,308

B. General Construction Type:

Exterior

Brick

Frame

Fire Resistant

Number of Stories

2

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building Site	41,988	1965-1978	\$ 34,000	1
2					2
3	TOTALS	41,988		\$ 34,000	3

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	129		1965	1955	\$ 179,090	\$	30	\$	\$	\$ 179,090	4
5	12			1969	67,135		30			67,135	5
6	48		1969	1973	401,170	13,372	30	13,372		367,737	6
7											7
8											8
	Improvement Type**										
9	Additions		1972		89,417	2,981	30	2,981		88,067	9
10	Additions		1974		30,006	1,000	30	1,000		26,503	10
11	Additions		1976		14,351	478	30	478		11,714	11
12	Sidewalk		1966		1,309		20			1,309	12
13	Sidewalk		1967		1,819		20			1,819	13
14	Fence		1970		5,795		15			5,795	14
15	Remodeling		1970		26,600	384	30	384		26,600	15
16	Sprinkler		1971		39,406		25			39,406	16
17	Tile Flooring		1971		12,097		20			12,097	17
18	Stairs Prock Enclosed		1972		19,211	640	30	640		18,245	18
19	Roofing Replaced		1972		3,783	126	30	126		3,592	19
20	Canopy		1972		1,339		20			1,339	20
21	Fencing		1972		2,016		15			2,016	21
22	Tile Floors		1973		4,718		20			4,718	22
23	Chain Link Fence		1974		3,589		15			3,589	23
24	Sprinkler System		1974		4,664		25			4,664	24
25	Nurses Station		1975		15,635		20			15,635	25
26	Switching Tiling		1975		13,706		20			13,706	26
27	Plumbing and Heating		1976		20,000	800	25	800		19,600	27
28	Tile and Toilets		1976		39,685		20			39,685	28
29	Sprinkler		1976		1,868	75	25	75		1,835	29
30	Tops and Caulking		1976		52,683		20			52,683	30
31	Tile		1976		6,796		20			6,796	31
32	Retile Building		1977		53,525		20			53,525	32
33	Plastering		1977		10,920		20			10,920	33
34	Carpentry		1978		5,152		20			5,152	34
35	Tile		1978		11,775		20			11,775	35
36	TOTAL (lines 4 thru 35)				\$ 1,139,260	\$ 19,856		\$ 19,856	\$	\$ 1,096,747	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Tuckpointing		1980	5,600	140	20	140		5,600	9
10		Hot Water Heater		1981	971	49	20	49		942	10
11		Doors, Etc.		1981	1,360	68	20	68		1,326	11
12		Ceramic Tile		1981	24,262	1,213	20	1,213		23,655	12
13		Additions		1982	14,743	737	20	737		13,635	13
14		Windows		1983	13,166	658	20	658		11,517	14
15		Windows		1987	2,365	118	20	118		1,595	15
16		Cameras		1987	1,091	55	20	55		738	16
17		Roof Improvement		1988	3,700	185	20	185		2,312	17
18		Heater		1990	1,240	124	10	124		1,302	18
19		Doors, Etc.		1990	3,543	177	20	177		1,860	19
20		Electrical		1990	2,202	110	20	110		1,156	20
21		Exit Doors		1991	19,211	961	20	961		9,126	21
22		Doors		1991	14,655	733	20	733		6,962	22
23		Electrical		1991	3,507	175	20	175		1,665	23
24		New Door		1992	1,330	67	20	67		566	24
25		Roof		1992	8,950	448	20	448		3,805	25
26		Windows		1992	3,150	158	20	158		1,340	26
27		Exit/Interior Door		1993	6,100	305	20	305		1,984	27
28		Remodel Nurse's Station		1994	16,000	800	20	800		5,600	28
29		Outside Door		1994	2,882	144	20	144		1,009	29
30		Remodel Nurse's Station		1994	20,300	1,015	20	1,015		7,105	30
31		Roof Replacement		1995	28,751	1,438	20	1,438		8,626	31
32		Remodel Nurse's Station		1995	17,710	886	20	886		5,314	32
33		Generator		1998	80,000	8,000	10	8,000		24,000	33
34		Air Conditioner/Monitor		1998	2,098	210	10	210		630	34
35		Hydra Electric		1999	900	45	20	45		90	35
36		TOTAL (lines 4 thru 35)			\$ 299,787	\$ 19,019		\$ 19,019	\$	\$ 143,460	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		DeCarlo Construction		1999	4,900	245	20	245		490	9
10		Storm Windows		1999	6,059	303	20	303		606	10
11		Wall Repair		1999	3,098	155	20	155		310	11
12		AC Prep		1999	1,824	92	20	92		184	12
13		New Fans		1999	1,932	97	20	97		194	13
14		AC Prep		1999	2,168	109	20	109		218	14
15		Exhaust Fans		1999	9,450	473	20	473		946	15
16		Radiator		2000	10,900	545	20	545		545	16
17		PTAK Unit		2000	8,606	430	20	430		430	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 48,937	\$ 2,449		\$ 2,449	\$	\$ 3,923	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Columbus Manor Residential Care Home # 0007781 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 992,264	\$ 44,812	\$ 44,812	\$	10/30	\$ 782,203	37
38	Current Year Purchases	5,066	254	254		10	254	38
39	Fully Depreciated Assets	477,982				15/20	477,982	39
40								40
41	TOTALS	\$ 1,475,312	\$ 45,066	\$ 45,066	\$		\$ 1,260,439	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Non Care Related	Cadillac '92	1997	\$ 25,344	\$ 2,534	\$ 2,534	\$	5	\$ 10,136	42
43	Facility Business	Ford '94	1993	23,204					23,204	43
44										44
45										45
46	TOTALS			\$ 48,548	\$ 2,534	\$ 2,534	\$		\$ 33,340	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,045,844	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 88,924	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 88,924	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,537,909	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	92 Cadillac/Purchased 1997	\$ 25,344	\$ 2,534	\$ 10,136	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 25,344	\$ 2,534	\$ 10,136	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____ </p>	<p>3. CLINICAL PORTION:</p> <p> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____ </p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12										
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 725,355	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	706,810		3
4	Supply Inventory (priced at)	1,800		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,519		6
7	Other Prepaid Expenses	2,290		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,452,774	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	755,645		15
16	Equipment, at Historical Cost	554,123		16
17	Accumulated Depreciation (book methods)	(984,217)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 325,551	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,778,325	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 79,613	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,015		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,478		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 190,105	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 190,105	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,097,165	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,287,270	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,097,165	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,097,165	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,065,781	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,571,727)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 494,055	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,591,220	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning: 1/1/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,770,945	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,770,945	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	35,040	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	174	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 35,214	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,466	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,466	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,808,625	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	872,028	31
32	Health Care	1,009,550	32
33	General Administration	602,141	33
B. Capital Expense			
34	Ownership	250,423	34
C. Ancillary Expense			
35	Special Cost Centers	8,702	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,742,844	40
41	Income before Income Taxes (line 30 minus line 40)**	2,065,781	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,065,781	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Columbus Manor Residential Care Home**# **0007781**Report Period Beginning: **1/1/00**Ending: **12/31/00****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,960	2,280	\$ 59,280	\$ 26.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,877	5,324	105,130	19.75	3
4	Licensed Practical Nurses	16,735	18,215	259,599	14.25	4
5	Nurse Aides & Orderlies	31,773	34,998	269,249	7.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,853	1,951	19,526	10.01	9
10	Activity Assistants	9,172	10,040	96,098	9.57	10
11	Social Service Workers	4,398	4,540	71,712	15.80	11
12	Dietician					12
13	Food Service Supervisor	1,855	2,031	23,185	11.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,191	11,314	97,714	8.64	15
16	Dishwashers					16
17	Maintenance Workers	5,753	6,393	81,276	12.71	17
18	Housekeepers	7,364	8,260	73,798	8.93	18
19	Laundry	1,952	2,200	21,590	9.81	19
20	Administrator	2,040	2,160	85,050	39.38	20
21	Assistant Administrator	2,040	2,080	43,757	21.04	21
22	Other Administrative	1,660	1,800	35,442	19.69	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,623	113,586	\$ 1,342,406 *	\$ 11.82	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	169	\$ 5,138	1-3	35
36	Medical Director				36
37	Medical Records Consultant	286	6,581	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1,654	43,840	11-3	44
45	Social Service Consultant	711	21,674	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,820	\$ 77,233		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Columbus Manor Residential Care Home

STATE OF ILLINOIS

0007781

Report Period Beginning:

1/1/00

Ending:

Page 23

12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. No
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ _____
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 21,972 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. See Accountants Report
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.